BLINDED VETERANS ASSOCIATION
TESTIMONY

PRESENTED BY
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BEFORE A JOINT SESSION OF THE
HOUSE AND SENATE
COMMITTEES ON VETERANS AFFAIRS

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INTRODUCTION

Mr. Chairman and members of these distinguished Committees, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative priorities. Before I begin, we wish to congratulate Chairmen Filner and Akaka, as well as ranking members Buyer and Craig on their new positions as the new chairmen and ranking members on the Committees on Veterans Affairs. The 110th Congress will handle many issues of paramount importance for which bipartisanship will be critical as we work together for the same goal: Caring for America's veterans.

BVA is the only Congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. Later this month, BVA will celebrate its 62nd anniversary of continuous work and service to this most unique group of Americans. We are especially proud of the close working relationship and strong support we have enjoyed from both of these Committees through the years. As a new generation of blinded veterans returns from Operation Iraqi Freedom and Operation Enduring Freedom, our combined efforts will be extraordinarily important in ensuring that these new veterans, and those from previous conflicts and wars, have the full continuum of high-quality accessible care. BVA greatly appreciated the strong support of members of these Committees in helping to pass the Blinded Veterans Continuum of Care Act, better known as the Blind Rehabilitation Outpatient Specialist (BROS) bill. Including it in S. 3421 resulted in 35 new BROS positions, thereby ensuring that blinded veterans would have increased access to vision rehabilitation services.

SEAMLESS TRANSITION ISSUES

During the past year, BVA has become increasingly frustrated by the many problems associated with the concept of Seamless Transition. Many severely eye-injured, now visually impaired OIF and OEF returning service members are not centrally tracked, making it impossible for them to be referred to VA Blind Rehabilitation Service (BRS) in a timely manner. This failure negatively affects their access to the full continuum of blind inpatient and outpatient rehabilitation programs and highly specialized low-vision treatment clinics. BVA would like to stress to these Committees that, in Department of Defense data compiled between March 2003 and April 2005, **16 percent of all casualties evacuated from Iraq had associated eye injuries**. Walter Reed Army Medical Center has surgically treated approximately 690 soldiers with either blindness or moderate to severe significant visual injuries while the National Naval Medical Center in Bethesda has had approximately 450 traumatic eye injuries requiring surgery. BVA has become increasingly frustrated with the lack of cooperation between the DOD Medical Treatment Facilities (MTFs) and VA BRS in failing to report all serious blind or low vision eye injury cases.

DOD currently reports well over 2,200 service members in various medical hold companies. They frequently wait for months for disposition of their Administrative Boards on Retention. BVA has discovered cases in which legally blinded service members in these medical hold companies wait up to six months before they are discharged, only to be then told to go find a local VA Medical Center for low vision or blind rehabilitation services. Officials within both Walter Reed Army Medical Center and National Naval Medical Center have occasionally refused

to provide VA BRS staff with the names and locations of visually impaired and blinded service members. These officials have hidden behind HIPPA regulations as a rationale for not providing VA personnel with this information. They went so far as to obtain a Judge Advocate General legal opinion last fall to support them in obstructing the transfer of this information. Service members with severe eye injuries will need VA specialized blind rehabilitation services for decades, but DOD is a stumbling block in this critical early intervention. Assistance that is vital in beginning the adjustment necessary to adapting to life as a legally blinded veteran must not be unduly delayed. We believe that the current DOD/VA Seamless Transition process associated with eye trauma cases is, at best, dysfunctional.

TRAUMATIC BRAIN INJURY

As of January 14, 2006, DOD reported that **more than 11,852 returning wounded had been exposed to potential Improvised Explosive Device (IED) blasts**. When considering the total 22,859 combat injuries, one must also acknowledge that Traumatic Brain Injury (TBI) has become the "signature injury" of OIF and OEF operations. Blast-related injury is now the most common cause of trauma in Iraq. One Army study found, for example, that 88 percent of military troops treated at an Echelon II medical unit in Iraq had been injured as a result of an IED explosion while 47 percent of those suffered TBI injuries.

BVA fully endorsed the increase in defense appropriations of $19 million in FY 2007 to treat TBI through the Defense and Veterans Brain Injury Center (DVBIC). We urge all members of these Committees to support increased funding for the DVBIC center in the FY 2008 appropriations. This vital research must continue as the number of TBI-injured rises. Two different cost analyses of the OIF/OEF impact on VA provide an alarming estimate of long-term costs. According to a recent study by researchers at Harvard and Columbia, it is estimated that the cost of medical treatment for service members with TBI will be at least $14 billion over the next 20 years. Another report had cost estimates above the $14 billion when factoring in lost wages of veterans and caregivers, vocational and educational costs, adaptive housing expenses, continued long term medical care, disability compensation, and unemployment.

POST-TRAUMATIC VISION SYNDROME

More than 1,850 of the total TBI-injured have been sufficiently wounded to the point of experiencing neurosensory complications. Epidemiological TBI studies have revealed that approximately 24 percent suffer from associated visual disorders of diploma, convergence disorder, photophobia, ocular-motor dysfunction, and an inability to interpret print. Some TBIs result in legal blindness and other manifestations such as **Post-Traumatic Vision Syndrome (PTVS)**. The VA Poly Trauma Center in Palo Alto has reported that 20 percent of all TBI patients in that facility in January 2007 have had PTVS. BVA believes that Congress should ensure the highest quality of ongoing screening of those at risk for TBI. Examining their exposure history is one way of doing so. There must also be continued education of DOD and VA medical staff on the identification, diagnosis, and appropriate consultative management of TBI. Continued support for vital TBI research is also a must, as is the enforcement of mandatory tracking of all service members who have sustained a mild to moderate TBI diagnosis.

The Veterans Health Administration (VHA) has reported that **41 newly returned service members have attended one of the ten VA BRCs**. Several others are in the process of being referred for admission, but we fear that many are unaccounted for and lost in the DOD system. In addition, 22 percent of the OIF wounded are from the National Guard or Reserves, with 44 percent of all wounded from communities of populations of less than 20,000. We believe that some of the eye-injured from this group have been lost and not referred for VA follow-up and appropriate VA BRS consultation if they have been sent for Tricare services through National Guard or reserve Community Health-Based Care Organization (CHBCO) programs. In a July 2006 meeting with VHA representatives, the DOD Severely Injured Service Center admitted that there was no central tracking system for eye injuries. We request that Chairman Mitchell's Subcommittee on Oversight work with both the Armed Services Oversight Committee and GAO to investigate what is being done about the Seamless Transition from DOD to VHA of treatments for traumatic visual injuries and TBI-related Post-Traumatic Vision Syndrome.

Service members who have suffered catastrophic life altering eye and TBI injuries deserve the Full Continuum of Care through VA BRS and Low Vision Services. They also deserve the other benefits available to assist them with their recovery. These numbers should highlight and make it very obvious to members of these Committees that a new generation of visually impaired, low vision, and blinded veterans are returning from OIF and OEF with unique TBI- related visual problems, PTVS neurological injuries, and direct eye trauma from IEDs. These Committees should find the data sufficiently important to hold future hearings on TBI-associated PTVS and visual injuries, ensuring that these active duty service members indeed experience a Seamless Transition. The failure of a proper and timely diagnosis, accompanied by an appropriate treatment of TBI and associated visual conditions, may prevent these veterans from performing basic activities of daily living, resulting in increased unemployment, failure in future educational programs, greater dependence on government assistance programs, depression, and other psychosocial complications.

ELECTRONIC HEALTH RECORDS

BVA is very concerned about the lack of substantial progress on the exchange of all health care records. We believe that DOD and VA must speed up the development of electronic medical records that are interoperable and bi-directional, allowing for a two-way electronic exchange of health information and occupational/environmental exposure data. We applaud DOD for beginning to collect medical and environmental exposure data electronically while military personnel are still in theaters of operation, but the actions accomplish little if the complete medical and surgical records of these future veterans cannot be accessed by both VHA and the Veterans Benefits Administration (VBA). The electronic medical records should include an easily transferable electronic DD214, forwarded from DOD to VA. Such a breakthrough would allow VA to expedite the claims process and give the service member faster access to health care and other benefits.

The Joint Electronic Health Records Interoperability (JEHRI) plan, agreed to by both VA and DOD through the Joint Executive Council and overseen by the Health Executive Council, is a progressive series of exchanges of related health data between the two departments. The ultimate desired result is the culmination of the bi-directional exchange of interoperable health information. The first two phases of implementation have met with some success, but BVA believes that a fully

integrated bi-directional system of electronic health records should already exist, given the billions of dollars already appropriated. However, failure to achieve real-time sharing of computable health information is due to the lack of health data standards in one of the electronic health record systems. In addition, technology is not wholly under the control of either department. Therefore, both of the respective Congressional Committees with oversight, VA and Armed Services, must demand these standards. BVA is not encouraged by reports that the timeline for full implementation moved from 2007 to 2012. In some instances, medical data gathered in theater and stored on electronic smart cards provided to the soldier are not readable by other military medical facilities upon the service member's return. When MTFs and VA providers at Poly Trauma Centers still today, four years into OIF, cannot access surgical records from different locations, one must conclude that two different organizational cultures are protecting expensive and inefficient contractor systems rather than working toward a fully seamless electronic medical records system.

Numerous letters of inquiry from Congress to VA and DOD, GAO investigations, Executive Order #5 (1998) directing the exchange of computer information, and many Congressional hearings expressing "deep concerns" about the timely lack of progress all point to a strong culture of resistance on the part of DOD and VA. Senior officials attempt to blame computer hardware/software programs and the "other old system" for not being able to provide each service member with a Seamless Transition. Efforts toward successful goal attainment in the area of electronic records remain largely uncoordinated. There is also a failure to make planning for transition a sufficiently high priority, despite assurances to the contrary. BVA suggests that Congress mandate that both DOD and VHA utilize only one computer electronic health care record system. We also ask that all discharged service members undergo one complete history and physical examination that can be used for both the Medical Evaluation Board and VBA in the streamlining of this process.

FUNDING VHA

Due to combat-related eye injuries in Iraq and an ever-increasing veteran population with the known prevalence of age-related visual impairment, the VA Visual Impairment Advisory Board (VIAB) has, for well over two years, identified and stressed the need for a uniform national standard for the full continuum of outpatient vision rehabilitation services. BVA was pleased with Secretary Nicholson's January 25, 2007 announcement that VHA would dedicate $40 million toward implementation of this continuum on behalf of America's blinded veterans. Nevertheless, the Continuing Resolution has delayed the process of implementation several months already. Because of the current discretionary appropriations process, none of the funding is currently available to implement these new outpatient programs.

Funding for the 35 new BROS over the next 30 months, authorized in the previously referenced S. 3421 as a first major step in providing efficient and cost effective services, will be also be delayed because of the Continuing Resolution. Again, for the seventh year in a row, VA health care has been forced to operate on such a basis well into the second quarter of the budget year. This is because Congress has not completed the appropriations process on time.

This year proved to once again be like most others with respect to the discretionary budget process. On October 1, VA did not have the FY 2007 appropriation necessary for its new budget cycle. It became business as usual as medical center directors and chiefs of staff stopped hiring, could not purchase or repair equipment, and halted or slowed down needed local construction projects while again waiting for their budgets. In FY 2005 and 2006, VA faced tremendous budgetary shortfalls that were subsequently addressed only through supplemental appropriations. The Administration submitted a budget request for FY 2007 that nearly matched most of the recommendations of the VSO Independent Budget, validating our analysis and budget projections. This is a change from past years in which budgets have been calculated on inadequate modeling projections that have left the system with major shortfalls. Such shortfalls have occurred because the funding models have not adequately accounted for the increasing costs of the aging population of veterans and of OIF/OEF veterans entering the system. We have, over the years, heard various high-level VA representatives admit that VA budget recommendations to the Administration have, before being sent to Congress, often been cut far below the projections made by the Independent Budget.

For FY 2007, the Administration requested $31.5 billion for veterans health care, a $2.8 billion increase over the FY 2006 appropriation. Although we recognize this as a significant step forward this year, we believe that the old modeling system must be replaced. The Independent Budget recommended approximately $32.4 billion for FY 2007, an increase of $3.7 billion over the FY 2006. Interestingly, it was $3.7 billion that was attached to the recently approved addition to the Continuing Resolution. Each year, the Administration's budgets approved by the Office of Management and Budget have subsequently revealed inaccuracies in what was needed. The Independent Budget, on the other hand, has been much more reliable.

The Independent Budget request for $36.3 billion for FY 2008 is what we feel is necessary. The Administration's figure is much closer to that of the Independent Budget, especially in its projection of $25.5 billion for medical services. We again disagree, however, with the Administration's desire to impose a new enrollment fee and to double the prescription drug co-payments. This sliding scale enrollment fee that the Administration recommends for Priority 7 and 8 veterans, and an increase in prescription drug co-payments from $8 to $15 for a 30-day supply that would go to the Treasury instead of VHA, should be rejected by Congress. We find it completely absurd that that these proposals of increased user fees would force nearly 200,000 veterans to leave the system while VA has also blocked tens of thousands of Priority 8 veterans from entering the system. In many cases these latter veterans have health insurance that would provide additional revenue for the VHA system.

PAIRED ORGAN LEGISLATION, H.R. 797

BVA has been very disappointed that these Committees would not vote on and approve "The Dr. James Allen Disabled Veterans Equity Act" (H.R. 2963), which had 80 bi-partisan co-sponsors. The need for this legislation exists because Title 38 of the United States Code Paired Organ law did not define legal blindness when it was enacted in 1962. Since that time, the Social Security Administration and every state law governing motor vehicle licenses has defined

blindness as visual acuity of 20/200 or less. The World Health Organization also accepts this definition.

In its own manual, the Veterans Benefits Administration (VBA) has nevertheless used a much stricter standard in defining blindness. The standard, located in Paragraph L of Section 1160, defines blindness at 5/200 (20/800). This means that veterans who have lost vision in a second eye have often had claims denied that would not have been denied to those applying for Social Security disability. In testimony last April (2006), we questioned both orally and in writing the fairness of this scenario to our blinded veterans. We stated that they should not be denied the same benefits that other paired organ veterans have received. Some 295 OIF returning service members who have been at Walter Reed Army Medical Center, 78 of whom have already been certified for service-connected blindness in one eye, could someday face the same denial of benefits experienced by World War II, Korean, and Vietnam veterans if paired organ legislation for blindness continues to fail.

Changing the Paired Organ statute to reflect the more commonly used definition of blindness would affect an estimated 5 percent of the 13,109 veterans between the age of 40 and 80 who are currently service connected for blindness and loss of vision in one eye, a fact we also emphasized in our April testimony to illustrate how little the legislation would cost. **The Congressional Budget Office has projected that the enacted legislation would cost less than $500,000 in FY 2007 and less than $2 million during the subsequent three years**. Nevertheless, the bill was reportedly blocked because of costs associated with it. For the 295 OIF veterans of which we are aware who are blinded in one eye, this sends a very disturbing message about the value of their vision.

Because VBA's budget for FY 2007 was not sufficient to even cover the minimal costs of implementation of these small changes in benefits for blinded veterans, the previous bill H.R. 2963 died in the 109th Congress. BVA appreciates the efforts of Representative Baldwin for introducing still another bill, H.R. 797, which has thus far received bi-partisan support and co-sponsorship by Representatives Boozman and Miller, Chairman Filner, and 27 other members of in the 110th Congress. Those supporting the bill are convinced that savings included in Section 2, which total more than $7 million over the first three years, will more than offset the costs of the bill.

VISION IMPAIRMENT SPECIALIST TRAINING ACT (VISTA), H.R. 1240

Public Law 104-262, The Eligibility Reform Act of 1996, requires VA to maintain its capacity to provide specialized rehabilitative services to disabled veterans, but it cannot do so when there are not enough specialists to address these needs. The aforementioned BROS bill passed last December increased the number of these specialists by 35 nationwide. However, there are an insufficient number of counselors certified in blind rehabilitation to provide for the growing number of blind or low-vision veterans, let alone the rest of our nation's elderly population.

Recently introduced by Representative Sheila Jackson Lee, the **Vision Impairment Specialists Training Act (VISTA), H.R. 1240, helps remedy this situation by directing the VA Secretary to establish a scholarship program for students seeking a degree or certificate in blind rehabilitation (Vision Impairment and/or Orientation and Mobility)**. The program will

provide an incentive to students considering entry into the field. In addition, in exchange for the scholarship award, students are required to work for three years in a VA health care facility to ensure that veterans are well cared for.

BLIND VETERANS FAIRNESS ACT, H.R. 649

The legislatures of New York, New Jersey, Pennsylvania, and Massachusetts currently provide a yearly annuity for blinded veterans who have sustained a total loss of sight as a result of service in any war. Blinded veterans in New York currently receive an annual payment of $1101.28. The figure is $750 in New Jersey, $1,800 in Pennsylvania, and $2,000 in Massachusetts. Under current law, however, such blinded veterans may actually lose part of their Supplemental Security Income (SSI) benefits for receiving this modest annuity from these states. Other state legislatures that might institute these annuities are reluctant to do so unless this problem is corrected legislatively on a national level.

H.R. 649 will exempt blinded veterans from this quirk in the Social Security Act by amending title XVI. **The new provision allows for annuities paid by states to blinded veterans to be disregarded in determining SSI benefits**." Currently, those receiving aid from SSI are allowed just over $600 in income per month (plus small state supplementals), demonstrating that SSI benefits are paid only to those with very modest total incomes. Anything above this amount is deducted from the recipients' benefits. To penalize blinded veterans in this category who selflessly served our Nation is entirely unfair.

VBA CLAIMS BACKLOGS REMAIN HIGH

A core mission of the VA Veterans Benefits Administration is to provide financial disability compensation, Dependency and Indemnity compensation, and disability pension benefits to veterans and their dependent family members and survivors. These payments are intended by law to relieve the economic effects of disability (and death) upon veterans and to compensate their families for loss. For those payments to effectively fulfill their intended purpose, VA must deliver them promptly and base such deliveries on accurate adjudications. The ability of disabled veterans to feed, clothe, and provide shelter for themselves and their families often depends on these benefits.

The need for financial support among disabled veterans is generally urgent. While awaiting action by VA on their pending claims, veterans and their families must often suffer hardships, resulting in protracted delays that can lead to deprivation and even bankruptcy. Some of our "Greatest Generation" veterans have died after waiting for years for their disability claims to be resolved. The newest second Greatest Generation is facing the same situation in years to come if action is not taken immediately to address this broken system. In sum, VA disability benefits are critical, and meeting the needs of disabled veterans should be a top priority of the federal government.

While boasting that it is breaking all records in awarding new claims for rightful benefits to OIF and OEF veterans, VA sits on hundreds of thousands of older claims filed by veterans of prior

conflicts and military service. Some of these new veterans who file additional claims a couple of years after their service are now running into the same long delays as veterans from previous wars. These claims lie dormant, awaiting some future resolution while disabled veterans suffer the consequences. We applaud VA's efforts to help our nation's new veterans but are dismayed when VBA continues to fail our older veterans by allowing the backlog to grow daily. Rather than making headway in overcoming the chronic claims backlog and consequent protracted delays in disposition of claims, VA has lost ground. The backlog of pending claims has grown substantially larger in recent years. In fact, the backlog of compensation claims grew from 363,412 in December 2000 to 589,583 in September 2006, an increase of 50 percent. During this same period, VA representatives stated publicly on multiple occasions that reducing the chronic backlog was their "highest management priority!" We also note that during this same period the staffing of VBA remained essentially flat at about 9,000 full-time employee equivalents. The total number of VBA compensation, pension, and burial benefit claims received in Compensation & Pension has increased by more than 9 percent for each of the past four years with a projection of 874,136 claims for FY 2007.

BVA agrees with the following assertion in the most recent **VSO Independent Budget Critical Issues Report**:

> Instead of requesting the additional personnel and funding needed to accomplish better results, the Administration has sought and Congress has provided fewer resources for VBA. Recent budget requests have proposed even reducing the number of full-time employees who process claims for VBA. Such reductions in staffing are clearly at odds with the realities of VBA's growing workload and its own well-established adjudication policies and procedures. Adjudication of veterans' claims is a labor-intensive, hands-on system of decision making with lifelong consequences. Our government's political and management decisions have conspired to diminish the quality of claims processing and to cause the agency to lose ground against the claims backlog.

During Congressional hearings, VA is indeed routinely forced to defend VBA budgets that it knows will be inadequate to the task at hand. This results in constant failure to meet the goal of identifying a long-term strategy in which VBA fulfills its mission and confirms the Nation's moral obligation to its disabled veterans. Congress and the Administration must invest adequate resources, increase staff training, improve the electronic exchange of military records, and commit to a new strategy to improve quality, proficiency, oversight, and efficiency within VBA.

BLIND REHABILITATION CENTERS (BRCs)

After almost 60 years of existence and progress, BRCs still provide the most ideal environment in which to maximize the rehabilitation of our Nation's blinded veterans. BRCs help them acquire the essential adaptive skills to overcome the many social and physical challenges of blindness. Despite the high-quality services and opportunities provided by BRCs, we discovered during FY 2006 that various facilities had staffing shortages, leaving beds empty while waiting lists remained unacceptably high.

BRCs are especially important for the returning OIF and OEF service personnel. Because they suffer from multiple traumas that include TBI, amputations, neurosensory losses, PTSD, and depression, the BRC can and must deliver the entire array of highly specialized care needed for them to optimize their rehabilitation outcomes and successfully reintegrate within their families and communities. Mr. Chairman, we wish to strongly emphasize that no private programs for the blind have all of the highly specialized services and prosthetics expertise that our residential blind centers have developed. There is environment of which we are aware that better facilitates the initial emotional adjustment to the severe trauma associated with the traumatic loss of vision than full, comprehensive blind rehabilitation. These centers need directed funding to bring staffing levels up to required levels. Therefore, VISN directors should not be allowed to divert funds, designated by Veterans Equity Resource Allocation (VERA) for admissions to blind centers, to general operations. There should be no closing of beds nor hiring freezes on critical blind center staff positions. VHA found last year that some of the ten centers utilized only 80 percent of their beds, and that 34 FTEE positions were vacant. This all happened as we received reports of four-month waiting times to enter several centers. VHA BRS should have more control over blind center resources and funding levels. When and if this additional control occurs, BRS will be better able to track demand for workload across all centers, monitor waiting times, and improve the overall allocation of critical resources in meeting demand.

With implementation of the Full Continuum of Care model announced in late January by Secretary Nicholson, more emphasis will be placed on outpatient programs. Although this development is a most positive one for blinded veterans in and of itself, there is a significant possibility, in the current structure and system of VISNs, that medical center directors may attempt to mandate BRC directors to cut even more staff FTEE, reduce the number of inpatient beds, or limit the training inherent in these highly specialized programs. We fear that such action would hurt the quality and excellent reputation of BRCs.

THE VISUAL IMPAIRMENT SERVICES TEAM (VIST)

The mission of each VIST program is to provide blinded veterans with the highest quality of adjustment to vision loss services and blind rehabilitation training. To accomplish this mission, VIST has established mechanisms to maximize the identification of blinded veterans and to offer a review of benefits and services for which they are eligible. The VIST concept was created in order to coordinate the delivery of comprehensive medical and rehabilitation services for blinded veterans. VIST Coordinators are in a unique position to provide comprehensive case management and Seamless Transition services to returning OIF/OEF service personnel for the remainder of their lives. They can assist not only the newly blinded veteran but can also provide his/her family with timely and vital information that facilitates psychosocial adjustment. Seamless Transition from DOD to VHA is best achieved through the dedication of VIST and BROS personnel. VIST Coordinators are now following the progress of 87 blinded OIF/OEF veterans who are receiving services as outpatients.

The VIST concept was first created in 1967. In 1978, VA established six full-time VIST Coordinator positions. The system now employs 93 full-time Coordinators who work an average

caseload of 375 blinded veterans. VIST Coordinators nationwide serve as the critical key case managers for some 44,700 blinded veterans, a number that is projected to increase to 52,000 within five years. It is BVA's belief that, as the current system transforms itself into a Full Continuum of Care Model with additional blind and low-vision outpatient programs, VA should increase the number of full-time VIST coordinators. These individuals are a critical component in the coordination of various services. We find that many VIST Coordinators are assigned to be part-time Coordinators handling ever-increasing workloads. This limitation is a significant barrier to the individual charged with directing hundreds of blinded veterans to efficiently utilize the variety of services available to them.

With recent Congressional authorization of 35 new BROS positions, the VIST/BROS teams will be able to provide improved local services when a veteran cannot attend a BRC. Given the demographic projections of visually impaired and blinded veterans, BVA believes and has always maintained that any VA facility with 150 or more blinded veterans on its rolls should have a full-time VIST Coordinator. BVA has found that the lack of VIST services is often due to the actions of local facility managers who seek to avoid the cost of even one FTEE position. In such cases, management has insisted that part-time positions manage these duties along with other collateral duties.

As a side note, many rural regions in the country have no local private blind services. BVA believes that the expertise and experience garnered by VA over several decades could also help other Americans needing vision rehabilitation services outside the VA system on a space available basis. Although this is not realistic at present because of the limited resources for large numbers of veterans needing the services, it might be something to be considered at a future time.

THE BLIND REHABILITATION OUTPATIENT SPECIALIST (BROS)

A highly specialized outpatient option offered by BRS is the aforementioned BROS program. This approach to the delivery of services is usually provided to blinded veterans who cannot attend a BRC program. Veterans who have attended a BRC and who would otherwise lack continuum of care follow-up are also beneficiaries. Such veterans in the latter case often require additional training due to changes in adaptive equipment or technology advances. Thanks again to recent legislation, BRS will be able to establish 35 new BROS positions over a 30-month period in facilities throughout the system. The creation of these additional BROS positions provides VA with an excellent opportunity to deliver accessible, cost-effective, top-quality outpatient blind rehabilitation services. We recommend that every VA primary and secondary Poly Trauma Center, 21 facilities in all, have a full-time VIST Coordinator and a full-time BROS. These VIST/BROS teams should be key contacts for every MTF caring for low-vision and blinded OIF/OEF service personnel requiring specialized services.

VISUAL IMPAIRMENT SERVICES OUTPATIENT REHABILITATION (VISOR)

In 2000, VA initiated a revolutionary program to deliver services: Pre-admission home assessments complemented by post-completion home follow-up. An outpatient, nine-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) offers skills training, orientation and mobility, and low vision therapy. This program combines many of the features of a residential blind center with those of outpatient service delivery. A VIST Coordinator with low-vision credentials manages the program with other key staff consisting of certified BROS Orientation and Mobility Specialists, Rehabilitation Teachers and Low-Vision Therapists, and a part-time Low-Vision Ophthalmologist.

According to VA Outcomes Project Research, patient satisfaction with the program is nearly 100 percent. The Visual Impairment Advisory Board's (VIAB) recent report recommended and endorsed a plan for this delivery model to be considered for replication within each VISN Network that does not have a BRC. The program uses hoptel beds to house veterans. The beds do not require 24-hour nursing coverage and are similar to staying in a hotel. Medical care is utilized within the VA Medical Center if needed for such outpatients. VISOR's annually projected caseload of 550 veterans (50 per VISOR facility) has an estimated cost of $8,545 per veteran, roughly one-third of the $28,900 for a one-month stay at a BRC.

VISUAL IMPAIRMENT CENTER TO OPTIMIZE REMAINING SIGHT (VICTORS)

Another important model of service delivery that does not fall under VA BRS is the VICTORS program. The Visual Impairment Center To Optimize Remaining Sight is an innovative program operated by VA Optometry Service. It consists of special services to low-vision veterans, who, though not legally blind, suffer from severe visual impairments. Generally, veterans must have a visual acuity of 20/70 through 20/200 to be considered for this service. The program, entirely inpatient, typically lasts five days. The veteran undergoes a comprehensive, low-vision optometric evaluation. Appropriate low-vision devices, sometimes several in number, are then prescribed. This process is then accompanied by necessary training with the devices so that independence in the daily lives of the veterans can be maximized.

The Low-Vision Optometrists employed in VICTORS programs are ideal for the highly specialized skills necessary for the assessment, diagnosis, treatment, and coordination of services for those returning from Iraq or Afghanistan with TBI or other injuries that have damaged their vision. The Palo Alto VA Poly Trauma Center and Eye Clinic, for example, have already initiated the screening of OIF/OEF veterans for PTVS. We call for at least eight new VICTORS urgently needed to meet the growing rehabilitation needs of recently returned service personnel. Veterans who are in most need of these programs are those who may be employed but, because of failing vision, feel they cannot continue to work. The VICTORS program enables such individuals to maintain their employment and retain full independence over their lives. Unfortunately, Mr. Chairman, only four such programs currently exist within VA. BVA and VIAB earlier recommended a total of eight new VICTORS outpatient programs during the FY 2007-08 time

period for which BVA requests your support. VICTORS could further assist legally blinded veterans who have already attended a residential BRC and received specialized low vision aids and who then require minor modifications. VICTORS also allows for testing the effectiveness of new technology aids through review, research, and the writing of new prescriptions when appropriate. Programs such as VICTORS and VISOR are very cost effective programs for high-need, low-vision veterans with residual vision from conditions like macular degeneration, diabetic retinopathy, and other co-morbidities.

More than a thousand OIF and OEF veterans, most of them relatively young, will soon need to be referred for low-vision services due to direct eye trauma and TBI. These individuals, found in all of the VISNs nationwide, will require the initial outpatient diagnostic/treatment programs and long-term follow-up services offered by VICTORS.

VA RESEARCH

VA-funded programs are less than one-third (30 percent) of the total VA research enterprise. Nevertheless, VA has failed to secure equitable reimbursement for indirect costs from all of its research partners, especially other federal agencies. In particular, BVA believes that the National Institutes of Health (NIH) should pay VA for the indirect costs of NIH-funded research grants. Currently, VA is one of the few entities not reimbursed for such costs, which means that medical care dollars must sometimes be used to cover them. To put this scenario into perspective, funding for indirect research would have provided VA with an additional estimated $25 million from NIH last year. These are funds that could have been used to provide medical care to veterans. We believe that this is grossly unfair, both to the sick and disabled veterans in need of care and to a health care system already forced to operate with constrained funding. NIH has resisted every effort by VA to change this procedure. VA investigators are to be applauded for their success in obtaining extramural grants, but the medical services and facilities appropriations should not bear the cost of the necessary infrastructure. We therefore believe that legislative action is essential.

Further exacerbating the inadequate funding for research is that the budget of the Rehabilitation Research & Development Service, one of the four components of the Office of Research & Development within VA, has recently been trimmed in favor of other priorities. In FY 2007, Congress increased the amount to $411 million. The Administration still requested only $411 million for FY 2008, hoping that VA could locate additional sources of funding. We again believe this to be unconscionable at a time when severely disabled service members are returning from war zones and need the very finest in research, training, and rehabilitative care. BVA feels that $411 million is unacceptable in view of the large increases in eye injuries. Future research could potentially preserve sight, restore lost functions, and/or prevent further deterioration. BVA endorses the recommendation of Friends of VA Research (FOVA) that the VA Medical and Prosthetics Research Program receive $480 million in 2008 to keep pace with biomedical research cost increases. The Biomedical Research and Development Price Index (BRDPI) for FY 2007 is projected at 3.4 percent. To keep the funding level steady for FY 2008, therefore, an additional minimum of $14 million over the FY 2007 allocation is required. Additional funding is necessary to bolster new research initiatives, which include the study of new veteran reintegration. They also include the VA Genomic Medicine program.

OVERSIGHT

Mr. Chairman, the last oversight hearing by the House Committee was held July 22, 2004. The purpose of the hearing was to receive GAO's report on VA BRS. The report stated that the priority should be VHA's ability to provide the full scope of preventative and acute care services through BRCs, VIST programs, BROS programs, VISOR, and VICTORS. The expansion of blind and low-vision specialized services, provided by VHA, are now critical in meeting demands resulting from OIF and OEF injuries. These services are also important to an aging population with eye diseases who could, with appropriate low-vision health care services, retain independence and be spared costly nursing home admissions. Congress has failed repeatedly to pass appropriations bills in a timely manner so that the VHA system could fund these critical new outpatient programs. The Continuing Resolutions for FY 2007 and those of the previous seven budget years are clearly hurting these plans. Congress must act in favor of assured, or mandatory, appropriations in the future so that such critical programs are not subjected to this vicious cycle each year. We urge additional oversight as a means by which the need for mandatory funding can be even more firmly established.

RECOMMENDATIONS SUMMARY

1. Mandatory funding and implementation of a Full Continuum of Care for blinded and visually impaired are inextricably linked. The lack of predictability and accountability in the budget process allows only the status quo to be maintained. If VISNs continue to receive their budgets almost halfway through a fiscal year, uncertain as to when Congress will approve the next year's funding, the expectation that such VISNs will invest in new initiatives is unrealistic. BVA strongly endorses the VSO Independent Budget recommendation that funding for veterans health care be removed from the discretionary budget process and converted to a mandatory system. This would not create a new entitlement. Rather, it would change only the procedures behind veterans health care funding, removing VA from the vagaries of the appropriations process. Until this proposal becomes law, however, Congress and the Administration must ensure that VA remains fully funded by means of the discretionary process.

2. BVA also endorses the VSO Independent Budget assertion that additional research is needed regarding the consequences of brain injury. More investigation relating to best practices for its treatment is also needed and warranted by VA to deal with the medical and mental health aspects of TBI. Research on the long-term consequences of mild to moderate TBI in OIF/OEF veterans, as well as similar injuries in previous generations of combat veterans, is a must. To ensure a smooth transition for veterans (and their caregivers) with TBI, VA should explore possible means of providing further assistance to immediate family members of brain-injured veterans. This would include additional resources, improved case management, and continuous follow-up.

3. Congress and VA should establish a new strategy, contingent on the premise that sufficient staff and other resources will be available, to maintain accurate adjudications and to reduce the claims backlog. As part of this strategy, VA should implement a new communications plan that seeks to better inform veterans and the organizations that represent them of the status and

progress of their claims. BVA opposes the initial involvement of attorney representation in this process.

4. Congress should mandate, with time benchmarks, a single, bi-directional, electronic health care records system for a truly efficient Seamless Transition. DOD and VA must implement a mandatory single separation physical examination as a prerequisite to prompt completion of the military separation process.

5. Legislation that would amend the Beneficiary Travel Regulation in Title 38 should be introduced. BVA believes that VA should be allowed to pay for the transportation of catastrophically disabled veterans who are accepted to one of the VA special disabilities programs and who are currently not eligible for travel benefits. Such veterans are already required to pay the SSA co-payment and a daily per diem rate during the rehabilitation period. Adding the burden of travel costs, which usually involves air transportation, serves as a strong disincentive to taking advantage of the world-class rehabilitation services offered by VA.

6. VHA should identify strategies to develop screening, diagnosis, education, and research in the area of TBI, especially as the issue relates to service personnel and OIF/OEF veterans. An authorization of $4 million for Post-Trauma Vision Syndrome should go to VHA for the VA/DOD Traumatic Brain Injury Optometric Rehabilitation Program at Walter Reed Amy Medical Center and selected DOD MTFs. Procedures should take effect immediately to collect and exchange all information on every OIF/OEF eye injury case involving total blindness, any significant loss of visual acuity, or loss of visual fields.

7. Passage of H.R. 797, the Veterans Equity Act, will provide a clear definition of legal blindness as it relates to paired organs. This legislation is essential to our service-connected veterans who are blind in one eye and who may develop blindness in the other eye later in life.

8. BVA strongly supports the provision of a full Cost of Living Adjustment (COLA) for veterans receiving disability compensation and for surviving spouses and dependent children receiving Dependency and Indemnity Compensation (DIC). It is extremely important that disabled veterans and surviving spouses keep pace with inflation due to health care costs associated with severe disabilities. Although the rate of inflation has been quite low in recent years, medical costs continue to rise. Such increases place pressure on a disabled individual's purchasing power. BVA is opposed to any attempt to means test the provision of service-connected disability compensation or DIC benefits.

9. BVA also supports the VSO Independent Budget's recommendation for changes in burial allowance benefits. While the present allowances were never intended to cover the full costs of burial, they now pay just 6 percent of what they covered when the National Cemetery Administration first started paying burial benefits. The Independent Budget recommends increasing the plot allowance from $300 to $745 and expanding eligibility to all veterans eligible for burial in a national cemetery, not just those serving during wartime. BVA also supports the recommended increase in the service-connected burial benefit from $2,000 to $4,100 and the nonservice-connected benefit increase from $300 to $1,270. These modest increases will make a more meaningful contribution to the burial costs of our veterans.

10. Congress should exact Concurrent Receipt legislation to totally repeal the inequitable requirement that veterans' retirement pay, based on longevity, be offset by an amount equal to their VA disability compensation.

11. Congress should also repeal the currently inequitable requirement that the amount of an annuity under the Survivor Benefit Plan be reduced on account of, and by an amount equal to, the amount received by a veteran under Dependency and Indemnity Compensation.

12. Every Primary and Secondary VA Poly Trauma Center should have full-time VIST/BROS teams. All DOD MTFs should use the VIST/BROS teams as key points of contact on behalf of any service personnel with blindness or low vision. Any VA Medical Center with more than 150 blinded veterans should staff one full-time VIST Coordinator.

13. Congress should pass the recently introduced Vision Impairment Specialist Training Act, H.R. 1240. Sponsored by Representative Sheila Jackson Lee, the legislation would provide a much-needed incentive for students considering entry into one of a number of career paths in the broad field of blind rehabilitation. The demand for Blind Rehabilitation Outpatient Specialists with expertise in Orientation and Mobility is presently high due to the large numbers of aging blinded veterans and those who have lost their sight in OIF/OEF operations.

14. H.R. 649, "The Blind Veterans Fairness Act," should be passed. The legislatures of New York, New Jersey, Pennsylvania, and Massachusetts currently provide a yearly annuity for blinded veterans who have sustained a total loss of sight as a result of service in any war. Under current law, however, lower-income blinded veterans may actually lose part of their Supplemental Security Income benefits for receiving this modest annuity from the state. This is a serious injustice for which additional legislation is necessary.

CONCLUSION

Once again, Mr. Chairman, thank you very much for the opportunity to present the Blinded Veterans Association's legislative priorities for 2007. Despite all that has been said and written about the progress that has been made, BVA is still extremely concerned that all blinded veterans have future access to the full continuum of services discussed here today. We are especially mindful at this time of our returning service personnel from Iraq and Afghanistan. The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that depends in large part on the willingness of our government to meet its obligation to them as veterans. Waiting will only increase the problems and expenses associated with this crisis. I will gladly answer any questions you or other members of these Committees may have concerning our testimony.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Blinded Veterans Association

The Blinded Veterans Association (BVA) does not currently receive any money from a federal contract or grant. During the past two years, BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

BVA is a 501c(3) Congressionally chartered, nonprofit membership organization.

BIOGRAPHICAL SKETCH

BVA National President Larry R. Belote, legally blind since 1970, has been a VA Advanced Clinical Practitioner for 33 years and a VIST Coordinator with the South Texas Health Care System since 1994. He earned a masters degree in social work and maintains a website of training materials at **www.larrybelote.com**.

Under Larry's direction, the South Texas VIST program has led the Nation in referrals to Blind Rehabilitation Centers numerous times. His facility was the first in the nation to use ScripTalk. He has pioneered a risk management model of care for blinded veterans and has been responsible for Agent Orange initiatives. He has co-authored a number of specialized benefits booklets for veterans and a training booklet utilized by families and friends of veterans. He is a graduate himself of a residential Bind Rehabilitation Center program.

Larry is a member of the Board of the San Antonio Low Vision Club, the San Antonio Seniors Program, and the San Antonio Low Vision Task Force. He was recognized by VA Secretary Anthony J. Principi in 2004 with the prestigious Secretary's Hearts and Hands Award. He and his wife, Motoe, have two adult children.